Multispecialty, Interprofessional Team (MINT) Memory Clinic Referral Form

*Please ensure that the referral is filled out completely. **Incomplete referrals will be returned.**

☐ Bowmanville Health Centre	☐ Courtice Health Centre	☐ Pickering Focus and Function Clinic
22 King St. E., East Wing 2nd Floor, Suite 201, Bowmanville Phone #: 905-576-2567 ext. 5235 Fax: #: 888-573-6653	1450 Hwy 2 E., Lower Level, Courtice Phone #: 905-721-4330 Fax #: 855-399-8339	1099 Kingston Road Unit 217, Pickering Phone #: 647-366-2343 Fax #: 647-366-2344
For Bowmanvile / Courtice Clinic: **Referrals only accepted from PCPs (Primary Care Physicians) from BHC (Bomanville Health Centre) and OCG (Oshawa Clinic Group).*		***For Pickering Clinic:*** **Referrals only accepted from PCPs of patients living in Durham Region.*

Patient Information

Last Name: First Name: DOB:

*HC#: VC: ☐ M ☐ F ☐ Other:

Address: Primary language: ☐ English ☐ French ☐Other:

Phone: Cell: Email:

Has the patient previously been seen by: ☐ Geriatrician ☐ Memory Clinic ☐ GAIN team ☐ Neurology

Alternate Contact

Last Name: First Name: Relationship:

Phone: Email:

☐ *Check here to indicate that you **recommend AND have the patient's verbal consent** for the Memory Clinic staff to **contact the person listed above** about this referral.

Reason for Referral

☐ Change in behaviour / Personality ☐ Delusions / Hallucinations

☐ Cognition / Memory ☐ Depression / Anxiety *Is this a longstanding psychiatric concern?* ☐ Y ☐ N

☐ Other Comments:

Additional Information

☐ Lives alone ☐ Frequent Falls ☐ Safety Concerns ☐ ***Driving** ☐ Recent Hospitalization

***Driving:** Our assessments elicit information about driving safety. By law, this may lead to the initiation of a report to the Ministry of Transportation. **Patients must be made aware of this.**

Patient is aware that driving safety will be part of the assessment? ☐ Y ☐ N

Please attach the following investigations (within 1 year) if available:

☐ Bloodwork ☐ Previous MoCA ☐ MRI / CT *(Head)* ☐ ECG ☐ Cardiology Consult Note

Referring Primary Care Provider

Name:	Billing #:
Signature: _____	Date:

In collaboration with: